

Personal reflection

Highlighting the mental health needs of Syrian refugees

Nadim Almoshmosh

This personal reflection discusses the author's personal involvement supporting the mental health needs of Syrian refugees. The mental health needs of this population includes a wide range of psychological problems that require further evaluation to fully understand. The scale of the problem is huge, affecting large numbers, some of whom were subjected to prolonged torture and witnessed daily bombardments. Many other factors add to the refugees' misery, including: their ordeal before reaching safety, uncertainty of the future, feelings of entrapment and humiliation. There are also the general effects of forced displacement, the stigma surrounding mental health issues, and lack of means and trained professionals. Host communities have been overwhelmed and unprepared to deal with such huge demands. While several aid agencies have been involved, there is a lack of coordination resulting in either missing out whole communities and duplication of efforts in others. Additionally, these challenging environments affect conducting studies with, often, highly frustrated populations and some results may be skewed as a result. This paper ends with suggestions of what can be done to improve approaches to providing some relief in this unprecedented and continuing crisis.

Keywords: forced displacement, mental health, refugees, Syria

Introduction

As the Syrian conflict enters its fifth year, the United Nations High Commissioner for Refugees (UNHCR) has warned that millions of refugees in neighbouring countries, and those displaced within the country, are caught within deteriorating conditions and facing an even bleaker future without more international support. In fact,

almost half of the entire Syrian population are now either internally displaced or refugees in neighbouring countries.

Being a psychiatrist of Syrian origin, I volunteered early on in the conflict to help cover some of the mental health needs of Syrian refugees. Since early 2012, I have made several visits to refugee camps and communities in Turkey and Jordan. The initial beliefs of most refugees were that this would be a short ordeal, in which they could cope with a strong sense of resilience and defiance. It was not long, however, before people started experiencing difficulties in adjusting to a new reality. For example, one can easily imagine the hardship experienced by large families living in tents. Being in confined spaces and often having to compete with others to meet the most basic needs added to the frustration of this usually proud people. Despair and hopelessness started to surface, with some general feelings of gloom as their 'temporary' stay continued, with no end in sight.

Mental health needs

Attention to mental health care, in this part of the world, is usually neglected and below standard at the best of times, let alone at times of huge, humanitarian crisis. Neighbouring countries are overwhelmed, and are simply unprepared to deal with such huge need.

Research has shown that current mental health needs of this population range from the general negative effects of hardship and emotional adjustment difficulties to the most severe end of the spectrum, including: complicated grief reactions, severe post-traumatic stress disorder (PTSD) and depression. Various humanitarian agencies

have arrived in the region, focusing more, understandably in the beginning, on meeting basic needs. However, as more humanitarian agencies arrived, the less coordination happened between them. The fact that these agencies each have a different focus in terms of dealing with mental health, as well as different terms and conditions, meant valuable efforts were being wasted. This is partly due to lack of coordination and often non-existent patients' information sharing. Little outreach work is done in the community, which means large numbers of suffering people can be missed.

With more and more refugees coming, some of the host countries were not, understandably, always welcoming. Further, restrictions on movement and allowing refugees to work are usually imposed. For many, usually hard working Syrians, this creates a feeling of entrapment which, in turn, has its own toll on them. This is combined with a sense of loss and ongoing humiliation, as people have to rely more and more on charities and UNHCR food vouchers. This is increasing, and has had a large impact on family members and able-bodied men, in particular. Previous research on the effects of loss and humiliation has shown that it is strongly linked with major depression and anxiety (Kendler, Hettema, Butera, Gardner, & Prescott, 2003). The effects of severe life events and the onset of depression are undeniable and were also highlighted by the work of Brown, Harris, & Hepworth (1995). Despite feeling relatively safe within new environments, the fact that the tragedy is continuing back home has also had its toll on the general mood of the population.

Effects of forced displacement

It is widely known that forced displacement has an uprooting effect on individuals. These include: feelings of estrangement; loss of identity and disorientation; insecurity; loss of role; disturbance of social networks and schooling; and occasional exploitation of

vulnerable populations by local communities. For some, there is also the intense fear for the fate of relatives left behind, or those who are missing. Of course, there are also the specific effects of severe trauma, torture and war atrocities that many refugees have witnessed, or experienced.

Some of the most common mental health problems I have noticed were *symptoms* of anxiety, sadness, hyper-vigilance, social withdrawal, relationship problems and flashbacks of recent trauma. Many would qualify for diagnoses of mental health disorders, i.e. PTSD or severe depression, but most cases I came across were of a varying degree of prolonged adjustment disorders.

Stigma surrounding mental illness in Syrian society remains very high, which means delay in assessments and often hinder follow-up for those who have found the courage to be seen in the first instance. I have no doubt that many severe cases of mental health problems in these communities continue to suffer in silence, for precisely the reason of stigma, and are compounded by the lack of trained mental health professionals.

Worst affected groups

There are horrific stories of torture and witnessing of violence, descriptions of intense fear of unpredictable bombardments and unforgettable scenes of killings. All of these have had a severe effects on many Syrians.

The worst affected cases I saw were, sadly, of young children who lost one or both parents and siblings and there are many children in this position. Some gave descriptions of horrific scenes they witnessed of their family members being brutally killed. It is long been argued that one of the most significant war traumas of all, particularly for young children, is simply separation from parents and this can be more distressing than the war activities themselves (Machel, 1996). Some Syrian children have experienced both separation and the witnessing of horrific violence.

There also some reported stories of rape and gang rape, which is a well known as a *weapon of war*. One can speculate that there are much higher numbers of unreported cases of rape and sexual violence, against both women and men. This may never be uncovered, because of the sensitivities and shame attached to surviving these crimes, combined with a lack of means to follow-up and prosecute.

Epidemiological studies

Several surveys and studies have been done by various groups, with some revealing high prevalences of PTSD, depression and anxiety. One has to be cautious about the outcome of these studies, as they are often done in challenging environments and with emotionally charged population samples. The high prevalence rates of some of these are hard to justify, as there are no comprehensive assessments with robust methodology being done. It is also hard to generalise the results, as often meaningful community samples and those of internally displaced persons are missed. As far as I know, there are no validated clinical scales to assess reactions to trauma within the Syrian population that can be used widely within various settings. Over-medicalising responses to stressful situations in these surveys can creep in, and lead to misrepresentation and overinflated prevalence rates.

Inability to mourn the loss of relatives, or missing persons, complicates the grief and can lead to hyper vigilance and various depressive and anxiety symptoms. Most refugees have lost one or more family members, as well as their houses and valuables in the process of becoming refugees. In such situations, one would expect people to be feeling miserable, with mixed feelings of frustration and anger which, in turn, can hinder engagement in studies or evaluation processes. Making clinical diagnoses of mental illnesses under these circumstances requires expert clinicians in order to

distinguish expected responses to circumstances from extreme stress. It is not the mere completion of survey tools. Many variables have to be taken into account when studies are conducted if we are to reach a more accurate picture of the psychosocial effects on people amid this crisis. This is an unprecedented, man-made disaster that I think will require unprecedented measures to uncover its true and full mental health consequences.

What can be done?

There is an urgent need for better coordination among aid agencies to better orchestrate their efforts to address the mental health needs of Syrian refugees, and those internally displaced. Many agencies work in the same towns and camps, which is not always necessary, and could mean duplication of efforts. Moving agency branches to different sites and areas, and further developing community outreach teams will help uncover the real mental health needs of people, as well as encourage other sufferers to come forward. There is a potential role required for the WHO to direct, map and streamline these efforts.

Teams and volunteers should be trained to encourage and highlight the importance of *self-help*, problem solving and the role of affected individuals in dealing with their conditions. Affected individuals' role is vital in all cases and it becomes even more important where there is lack of resources. Unfortunately, this is often forgotten, ignored or not fully understood. Using the *WHO mental health Gap Action Programme* (mhGAP) training to develop more skilled volunteers in primary health settings, in order to help in the psychosocial support efforts, would help (WHO, 2010). Also, ensuring workers and volunteers are well supported and supervised is important to reduce burn out. More psychiatrists, psychologists and trained mental health nurses are needed to achieve this task, as well as use of innovative ways to help support volunteers i.e. Telemedicine,

video-conferencing sessions, and providing supervision using internet facilities etc. More, well conducted, research and epidemiological studies with validated scales to better understand the current mental health needs of Syrians should be encouraged. Culturally sensitive tools that take into account local population needs are important to develop. I, therefore, call on academic institutions and research centres to give this priority, as there are lots of lessons to be learnt from the mental health effects of this prolonged crisis.

References

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Dr Nadim Almshosh, is a Consultant in General Adults Psychiatry at Pulse Healthcare Ltd, UK
email: nalmshosh@gmail.com